

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MD
00484
00481
Item 7 Film 0307 2/23/62 1wk
MAY 1962
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b Less than 24hrs.		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital	
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAY		Middle A.		Last ALESHIRE		4. DATE OF DEATH Month January Day 26 Year 19 62	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-27-12	
9. AGE (In years last birthday) 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Aleshire		14. MOTHER'S MAIDEN NAME Lula Southard		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 719-16-3101	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. Pulmonary edema and congestion, bilateral, severe DUE TO (b) 2. Cirrhosis of the liver. DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH 48-72 hrs		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1-26-62 Rising Sun, Md.							
ACTUAL SIGNATURE R. C. DODSON		EXAMINER'S NAME (Type) R. C. DODSON					
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 1/31/1962		22c. NAME OF CEMETERY OR CREMATORY Arlington		22d. LOCATION (City, town, or country) (State) Arlington, Va.	
23. FUNERAL DIRECTOR Baltimore & Son, Havre de Grace, Md.		ADDRESS		24a. REC'D BY REGISTRAR FEB 5 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kross	

THE STATE
HEALTH DEPT.



1922

July

Births

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN lb all life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 226 W. High					d. STREET ADDRESS 226 W. High				
3. NAME OF DECEASED (Type or print) First Anna Middle Elizabeth Last Andrew					4. DATE OF DEATH Month 1 Day 18 Year 1962				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-18-1916		9. AGE (In years last birthday) 45 yrs.	10. IF UNDER 1 YEAR Months 1 Days 18		11. IF UNDER 24 HRS. Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Keeping House		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Isadore Garrett			14. MOTHER'S MAIDEN NAME Mary Hitchens						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no			16. SOCIAL SECURITY NO. -----		17. INFORMANT Robert W. Andrew. 226 W. High St. Elkton, Md				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rising Sun, Md.		(County) Md.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE R.C. Dodson			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 1-19-62
EXAMINER'S NAME (Type) R.C. Dodson M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			Address (City, town, or country) Rising Sun, Md.			(State) Md.
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 22, 1962		22c. NAME OF CEMETERY OR CREMATORY IMMACULATE CONCEPTION CEMETERY		22d. LOCATION (City, town, or country) NR. ELKTON, Md.		(State) Md.	
23. FUNERAL DIRECTOR PIPPIN FUNERAL HOME			ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR JAN 24 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Krane		



Book I

Section

220 W. High

Ann

W

Houswife

Isabelle Garrett

no

Book I

Section

220 W. High

Andrew

6-18-1910

Maryland

Mary Hitchman

Book I

I

18

62

U.S.A.

Robert W. Andrew, 220 W. High St., Elkton, Md

Acute Concomitant Oculation

2 min.

x

x

x

Rising Sun, Md.

1-12-32

H. J. Johnson M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00486

00483

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, if institution; Residencia before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Howard Middle Graham Last Barnes			4. DATE OF DEATH Month Jan. Day 12 Year 19 62		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 7, 1886		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (County & State, or foreign country) Cecil Co., Md	
12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME William Barnes			14. MOTHER'S MAIDEN NAME Isabella Trelford		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 218-36-1866		
17. INFORMANT Florence Rawlings Barnes,			Address Port Deposit, Md. R.F.D.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arterio-Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4-20-61 (b) 3 yrs (c) 8 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 yrs 8 yrs					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Jan 5, 1962		20g. (County) Jan 12, 1962		20h. (State) Jan 12, 1962	
21. I certify that (I) (this hospital) attended the deceased from Jan 5, 1962 to Jan 12, 1962; that (I) (we) last saw the deceased alive on Jan 12, 1962 and that death occurred at Jan 12, 1962, from the causes and on the date stated above.					
22a. SIGNATURE Clarence I. Benson			22b. DATE SIGNED Jan 13-62		
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			22d. ADDRESS Port Deposit, Md.		
23a. BURIAL, CREMATION, REINTERMENT Burial		23b. DATE THEREOF 1-15-1962		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery	
23d. LOCATION (City, town or county) Port Deposit, Md. Rural		23e. (State) Port Deposit, Md. Rural			
24. FUNERAL DIRECTOR'S SIGNATURE Veel A. Patterson & Son,			25a. REC'D BY REGISTRAR JAN 17 '62		
25b. REGISTRAR'S SIGNATURE Arthur L. Kincaid			25c. ADDRESS Perryville Md.		

00121

(M)

Casey

Married

Casey

Married

Port Deposit, Md.

Life

Port Deposit, Rural

18 18 18

Jan.

Married

Stephen

Lowry

Nov. 7, 1880

White

Male

18 18

Casey Co., Md.

Lawson

Robert

Traylor

Isabella

Betha

William

Port Deposit, Md.

21-24-1884. Florence Lawrence Brown, Wm. R. D.

8/18

to be given to the

for 2 to 4 years

to be given to the

Stephen L. Hanson, M.D. Port Deposit, Md.

Port Deposit, Md. Rural

Hopewell Cemetery

1-10-1884

Partial

Port Deposit, Md.

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00487

00484

1. PLACE OF DEATH e. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Earleville d. STREET ADDRESS Bohemia Heights e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 20 days															
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital of Cecil County																			
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Taylor Beattie				4. DATE OF DEATH Month Day Year Jan 23 1962															
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH (1899) June 16, 1899		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hsuf.				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Chelsea, mass				12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Jere Taylor				14. MOTHER'S MAIDEN NAME Nellie Hayes				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO.				17. INFORMANT Address Mildred Beattie (Hospital Records)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basal Hemorrhage (Hemorrhage at base of brain) 2043 DUE TO Acute lymphocytic leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days 2 months.												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Dec 1 1962 to 23 Jan 1962, that (I) (we) last saw the deceased alive on 23 Jan 62 1962, and that death occurred at 7:00 AM from the causes and on the date stated above.																			
22e. SIGNATURE Wallace Obenshain M.D.								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 24 Jan 62							
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.								22d. ADDRESS Cecilton, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 1/24/62		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery Co. Wilmington, Del.				23d. LOCATION (City, town or county) (State)									
24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks								ADDRESS Elkton, Md.				25a. REC'D BY REGISTRAR JAN 31 '62 DATE		25b. REGISTRAR'S SIGNATURE Arthur L. Francis					

M

00487

Taylor

Greenston 1/24/32
Silverbrook Cemetery Co. Wilmington, Del.
Binton, Md.

VS. A15ME
5M 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 13 years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Walnut Lane		d. STREET ADDRESS Walnut Lane	
3. NAME OF DECEASED (Type or print) Elizabeth W. Benjamin		4. DATE OF DEATH Month 1 Day 4 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 13, 1878	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0	
IF UNDER 24 HRS. Hours 0 Min. 0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Gustavus Warner	
14. MOTHER'S MAIDEN NAME Angela Caldwell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs Edmund W. Crothers Elkton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) General arteriosclerosis DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 5 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-5-1962	
Address (Street, city, town, or county) Rising Sun, Md		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 1-7-1962		22c. NAME OF CEMETERY OR CREMATORY Methodist	
22d. LOCATION (City, town, or country) (State) North East, Cecil Co. Md		23. FUNERAL DIRECTOR Joseph R. Grant	
ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE JAN 8 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH e. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chesapeake City d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chesapeake City d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Margaret A. Blanchfield					4. DATE OF DEATH Month January Day 19 Year 1962						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1899		9. AGE (In years last birthday) 62 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days Hours Min.			
13. FATHER'S NAME John H. Green					14. MOTHER'S MAIDEN NAME Martha A. Allen						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Samuel T. Blanchfield, Chesapeake City, Md. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Hypertensive Cardiovascular disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Rheumatoid arthritis severe DUE TO Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis severe										INTERVAL BETWEEN ONSET AND DEATH 8 hrs Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from Jan 19, 1962 to Jan 19, 1962 , that (I) (we) last saw the deceased alive on Jan 19, 1962 , and that death occurred at 145 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Tillman D. Johnson M.D.					22b. DATE SIGNED						
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D.					22d. ADDRESS 123 Singsley Ave, Elkton, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 22, 1962		23c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		23d. LOCATION (City, town or county) (State) Cecilton, Cecil Co; Md.		25a. REC'D BY REGISTRAR JAN 23 '62			
24 FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.					25b. REGISTRAR'S SIGNATURE Arthur L. House						

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the Director. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00490 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00487

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Earlville R.D.1. c. LENGTH OF STAY IN lb all life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Md. b. COUNTY CECIL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Earlville, R.D.1. d. STREET ADDRESS 1 a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Mayrice Edward Brown			4. DATE OF DEATH Month Day Year 1 30 19 62		
5. SEX M			6. COLOR OR RACE W		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 9-21-1917		
9. AGE (In years last birthday) 44 yrs.			10. IF UNDER 1 YEAR Months Days 44		
11. IF UNDER 24 HRS. Hours Min. 44			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Hand			10b. KIND OF BUSINESS OR INDUSTRY Farming		
11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James M. Brown			14. MOTHER'S MAIDEN NAME Bessie L. Wiltback		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) yes M.W.2			16. SOCIAL SECURITY NO. 218-2602606		
17. INFORMANT Mrs. Edward M. Brown, Earlville R.D.1. Md.			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 5 minutes					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
DATE SIGNED 1-30-62					
ACTUAL SIGNATURE R.C. Dodson M.D. EXAMINER'S NAME (Type) R.C. Dodson M.D. Address Rising Sun, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF Feb. 2, 1962					
22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery					
22d. LOCATION (City, town, or country) (State) Galena, Kent Co; Md.					
23. FUNERAL DIRECTOR Edward Fellows, Millington, Md.					
24a. REC'D BY REGISTRAR DATE FEB 2 '62					
24b. REGISTRAR'S SIGNATURE Arthur S. Hines					



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2-21-1917

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1-30-62

James M. Brown

James M. Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be made by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Warwick c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)												2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Warwick Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) Albert R. Bryant						4. DATE OF DEATH January 9, 1962																													
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May, 12, 1882		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer						10b. KIND OF BUSINESS OR INDUSTRY Own Farm						11. BIRTHPLACE (County & State, or foreign country) Phila. Pa.						12. CITIZEN OF WHAT COUNTRY? U.S.A.																	
13. FATHER'S NAME Thomas E. Bryant						14. MOTHER'S MAIDEN NAME Hannah B. French																													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)						16. SOCIAL SECURITY NO. 217-36-4843						17. INFORMANT Mrs. Catherine O. Bryant, Warwick Md.																							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ANEURISM OF ABDOMINAL AORTA INTERVAL BETWEEN ONSET AND DEATH 3 yrs												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																							
21. I certify that (I) (this hospital) attended the deceased from APRIL 8, 1961, to JAN 9, 1962, that (I) (we) last saw the deceased alive on JAN 8, 1962, and that death occurred at 2:37 AM, from the causes and on the date stated above.																																			
22a. SIGNATURE Henry V. Davis MD												22b. DATE SIGNED 1/16/62																							
22c. PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD												22d. ADDRESS CHESAPEAKE CITY MD																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF Jan. 13, 1962						23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery						23d. LOCATION (City, town or county) (State) Galena, Kent Co; Md.																	
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows												25a. REC'D BY REGISTRAR DATE JAN 15 '62												25b. REGISTRAR'S SIGNATURE Arthur S. Hume											

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CERTIFICATE OF DEATH

00492

00489

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Port Deposit c. LENGTH OF STAY IN 1b Life ? d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 276 N. Main St.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residencia before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit d. STREET ADDRESS 276 N. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Walter C. Camburn First Middle Last				4. DATE OF DEATH Jan. 23 19 62 Month Day Year											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1889		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Day		11. BIRTHPLACE (County & State, or foreign country) Maryland Pa				12. CITIZEN OF WHAT COUNTRY? U S A					
13. FATHER'S NAME John Camburn						14. MOTHER'S MAIDEN NAME Clara E. White									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No				16. SOCIAL SECURITY NO. 216-09-6699		17. INFORMANT Address John Maloy, Port Deposit, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying causa last. } DUE TO (b) Coronary Sclerosis DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocarditis														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov-20 61 to Jan 23 62 , that (I) (we) last saw the deceased alive on Jan 23 1962 , and that death occurred at 11:00 M, from the causes and on the date stated above.															
22a. SIGNATURE Clarence I. Benson M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 1/24/62					
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson, M D						22d. ADDRESS Port Deposit, Md.									
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial				23b. DATE THEREOF 1-26-1962		23c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.				23d. LOCATION (City, town or county) (State) Colora, Md. Rural					
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son,						ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR JAN 26 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

00490

00493

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>215 West High St</u>			
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>A.</u> Last <u>Castle</u>				4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>19 62</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/1873</u>		9. AGE (In years last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Simmons.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>216-03-7863A</u>		INFORMANT <u>Mrs Linda Jenkins</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1</u> , 19 <u>61</u> , to <u>Jan. 16</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>Jan. 15</u> , 19 <u>62</u> , and that death occurred at <u>12:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>233 E. Main Street</u> DATE SIGNED <u>1/16/62</u>							
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u>		M.D. <u>233 E. Main Street</u>					
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>		<u>Elkton</u> <u>Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/19/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bethel Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Walter duBoise, Jr.</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 22 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item 206 File 307 2-9
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00491

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS 221 Howard Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frances McNeal Cleaves		4. DATE OF DEATH Month January Day 18 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1885
9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR: Months 7 Days 18 IF UNDER 24 HRS.: Hours 18 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher 10b. KIND OF BUSINESS OR INDUSTRY Principal 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Mitchell Cleaves		14. MOTHER'S MAIDEN NAME Dora Wanick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. Miss Mildred Cleaves, 221 Howard St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melastotic fracture of humerus + ex. humerus DUE TO (b) Carcinoma of breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) at home Pathological fracture - raising herself in bed. 20c. TIME OF INJURY Month, Day, Year 2 Dec 1961 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home 20f. (City or town) (County) (State) Elkton Md			
21. I certify that (I) (this hospital) attended the deceased from July 1961 19 to Jan 18 1962 18 that (I) (we) last saw the deceased alive on Jan 18 1962 and that death occurred at 3:15 PM from the causes and on the date stated above.			
22a. SIGNATURE Henry V. Davis		22b. PHYSICIAN'S NAME (Type) HENRY V. DAVIS M.D.	
22c. SIGNATURE Ralph E. Hicks		22d. ADDRESS CHESAPEAKE CITY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/21/62	
23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION (City, town or county) (State) Elkton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		25a. REC'D BY REGISTRAR DATE JAN 31 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. House		22e. DATE SIGNED 1/18/62	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Apr. 11, 1982

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School Teacher

Principal

Maryland

U.S.A.

Henry Mitchell Cleaves

Dora Wainick

Nikton, Md.

Miss Wilfred Cleaves, 281 Howard St.

No

1/21/82

Portia

Nikton Cemetery

Nikton, Md.

Nikton, Md.

TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. Page may be obtained by the hospital or attending physician. Page may be obtained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00495

00492

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MD b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL ELKTON		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle C Last COLE				4. DATE OF DEATH Month 1 Day 22 Year 1962			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-1-1879	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 1 Days 22		IF UNDER 24 HRS. Hours 22 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY GENERAL BUILDING		11. BIRTHPLACE (County & State, or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME CLARK COLE				14. MOTHER'S MAIDEN NAME MARY ELLEN BORLAND			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Albert R Wilson Elkton RD Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crohn's Insufficiency 42111 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic paraneoplastic nephritis DUE TO (c) Arterio Sclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 years 2 years 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Hypotension						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1, 1961 to Jan. 22, 1962 that (I) (we) last saw the deceased alive on Jan. 22, 1962 and that death occurred 22 PM , from the causes and on the date stated above.							
22a. SIGNATURE James L. Johnson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/22/62	
22c. PHYSICIAN'S NAME (Type) JAMES L. JOHNSON				22d. ADDRESS 245 E. 1st St. Elkton Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-24-1962		23c. NAME OF CEMETERY OR CREMATORY Sharpo		23d. LOCATION (City, town or county) (State) Fair Hill Cecil Co., Md	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph R Grant				ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 30 '62	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kenna			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00498

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00493

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chesapeake City				c. LENGTH OF STAY IN Life			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) EDWIN NELSON COOLING				4. DATE OF DEATH January 13, 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 28, 1889	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yacht Captain				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Zachary T. Cooling				14. MOTHER'S MAIDEN NAME Josephine Loveless			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ebbie B. Cooling	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Pulmonary T. B. (c)				INTERVAL BETWEEN ONSET AND DEATH 48 Hrs 2 Yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
18a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				18b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R. C. Dodson, M.D.				DATE SIGNED Jan. 13, 1962			
EXAMINER'S NAME (Type) R. C. Dodson, M.D.				DEPUTY MEDICAL EXAMINER Rising Sun, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/62		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or country) (State) Nr. Chesapeake Coty, Md.	
23. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME Elkton, Md.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be marked "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE

EXAMINATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00497

00494

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 9 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air d. STREET ADDRESS 417 Giles Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) EMMETT CULVER		4. DATE OF DEATH Month 1 Day 19 Year 1962			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-97	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Selvara, Penna.	
13. FATHER'S NAME Hiram Culver (Deceased)			14. MOTHER'S MAIDEN NAME Lucy Phinney Finney (Deceased)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WM-11		16. SOCIAL SECURITY NO. 166-16-5301		17. INFORMANT Address Hospital Records, VAH, Perry Point, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED, SEVERE				INTERVAL BETWEEN ONSET AND DEATH 45 Mins. Unk. Unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-10-1962 to 1-19-1962 , that (I) (we) last saw the deceased alive on 1-19-1962 , and that death occurred at 4:15 PM on the causes and on the date stated above.					
22a. SIGNATURE J. L. Garey J. L. Garey, M.D.			22b. DATE SIGNED 1/20/62		
22c. PHYSICIAN'S NAME (Type) J. L. Garey, M.D.			22d. ADDRESS VAH, Perry Point, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF JAN. 22, 1962		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster Joseph W. Foster		25a. REC'D BY REGISTRAR JAN 23 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00498

00495

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u> c. LENGTH OF STAY IN b. <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>UNION Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural ELKTON X</u> d. STREET ADDRESS <u>P.E.D.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Jane Curry</u>		4. DATE OF DEATH Month Day Year <u>JAN 16 1962</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>MAY 10, 1892</u> 9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired House</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>SHERDIA MARSH</u> 14. MOTHER'S MAIDEN NAME <u>LIDIA SINGLETON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> 16. SOCIAL SECURITY NO. <u>?</u> 17. INFORMANT <u>Charles A. Curry</u> Address <u>HAYREDE GRACE, MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 42000 DUE TO <u>Pulmonary Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>ASND = Heart Failure</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>?</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> , 19 <u>62</u> to <u>1/16</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/15</u> , 19 <u>62</u> , and that death occurred at <u>10:52</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			
<u>BURIAL</u>		<u>JAN. 19, 1962</u>		<u>HARMONY CH. YARD</u>			
23d. LOCATION (City, town or county)		(State)		23e. REC'D BY REGISTRAR			
<u>HARFORD Co.</u>		<u>MD</u>		23f. REGISTRAR'S SIGNATURE <u>[Signature]</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>HAYREDE GRACE, MD</u>				25a. DATE <u>JAN 23 '62</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00499

00496

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN TB 19 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood d. STREET ADDRESS 13 McCann a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) JAMES C. DUNN		4. DATE OF DEATH Month January Day 9 Year 19 62		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-21-27		9. AGE (In years last birthday) 34 yrs. IF UNDER 1 YEAR: Months 34 Days 34 IF UNDER 24 HRS.: Hours 34 Min. 34			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10b. KIND OF BUSINESS OR INDUSTRY Air Frame				11. BIRTHPLACE (County & State, or foreign country) Virginia, Glade Springs				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Lilburn C. Dunn						14. MOTHER'S MAIDEN NAME Edna Carlton									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW-II				16. SOCIAL SECURITY NO. 216-24-5335				17. INFORMANT Hospital Records, VAH, Perry Point, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) BRONCHOPNEUMONIA, BILATERAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 182X (b) CARCINOMA OF LEFT LUNG WITH METASTASIS TO BRAIN DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 3-5 Days 5-6 Mths.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. VA p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that XXXXXX A.L. MOONEY attended the deceased from December 21 1961 , to January 9, 1962 and that death occurred 1:20 pm from the causes and on the date stated above.															
22a. SIGNATURE A.L. Mooney						22b. DATE SIGNED 1-10-62									
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.						22d. ADDRESS 1:20 pm									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 13, 1962				23c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial				23d. LOCATION (City, town or county) (State) Abingdon, Harford, Maryland.			
24. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son, Abingdon, Md.						25a. REC'D BY REGISTRAR JAN 15 '62				25b. REGISTRAR'S SIGNATURE Arthur L. Hume					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00497

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPHINE FEIFER		4. DATE OF DEATH Month Day Year JANUARY 9, 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH UNKNOWN-1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No info.		14. MOTHER'S MAIDEN NAME No info.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Address MRS. JOHN SUBOLEFSKY - CHESAPEAKE CITY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebrovascular accident with right hemiplegia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 30 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 25, 1961 , to Jan. 9, 1962 that I last saw the deceased alive on Jan. 9, 1962 , and that death occurred at 12:35p from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 1/9/62	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		Elkton Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/12/62	22c. NAME OF CEMETERY OR CREMATORY ST. ROSES CEMETERY	22d. LOCATION (City, town, or county) (State) CHESAPEAKE CITY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. H. PIPPIN FUNERAL HOME		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR JAN 15 '62		24b. REGISTRAR'S SIGNATURE John E. Hines	



00400

CERTIFICATE OF DEATH

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WEST VIRGINIA BUREAU OF HEALTH
CERTIFICATE OF DEATH

NAME: _____
AGE: _____
SEX: _____
RACE: _____
DATE OF BIRTH: _____
DATE OF DEATH: _____
PLACE OF BIRTH: _____
PLACE OF DEATH: _____
CAUSE OF DEATH: _____
MANNER OF DEATH: _____
SIGNATURE OF DECEASED: _____
SIGNATURE OF WITNESS: _____
SIGNATURE OF PHYSICIAN: _____
SIGNATURE OF CLERK: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00501

00498

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN b 1yr4mos5days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK d. STREET ADDRESS 6905 Prince George Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last FOSTER		4. DATE OF DEATH Month January Day 27 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 8, 1923
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 27 Hours 10 Min. 05	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Routeman		10b. KIND OF BUSINESS OR INDUSTRY Dry Cleaning	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE E. FOSTER		14. MOTHER'S MAIDEN NAME EMMA WATSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-2 578-16-0162	
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction. 420.0 DUE TO (b) Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 3 to 4 hrs. 3 to 4 hrs. Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 11 (this hospital) attended the deceased from Sept. 22, 1960 to Jan. 27, 1962 that 11 (we) last saw the deceased alive on January 27, 1962 , and that death occurred at 10:05 PM from the causes and on the date stated above.			
22a. SIGNATURE A.L. Mooney M.D.		22b. DATE SIGNED 1-28-62	
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, M.D., Asst. Clinical Pathologist, VAH., Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 1-28-62	23c. NAME OF CEMETERY OR CREMATORY George Washington Memorial, Adelphia, Maryland	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Nally Funeral Home, Inc. ADDRESS MT. RAINIER, MD.		25a. REC'D BY REGISTRAR JAN 31 '62 DATE	
		25b. REGISTRAR'S SIGNATURE Carlton S. Frank	

Removal 1-28-62 George Washington Memorial, Washington, Maryland

A. L. COOPER, M.D., Chief, Clinical Pathology, VAH, Fort Point, Md.

O. J. WATKINS, M.D., Chief, Pathology, VAH, Fort Point, Md.

January 27 62

Sept. 22, 1962
10:02

Fort Point, Md.

62

11

Yes

W-2

Acute myocardial infarction

Coronary atherosclerosis

Arteriosclerotic heart disease

Unknown

3 to 4 hrs.

3 to 4 hrs.

576-16-0162 Hospital Records, VA Hospital, Fort Point, Md.

GEORGE E. FOSTER
2001 WATSON

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Ray, Glenning

Washington, D.C.

1954

Male White

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December 8, 1953 38

GEORGE

EDWARD FOSTER

January 27, 62

62

Veterans Administration Hospital

605 Prince George Street

TAKOMA PARK

12710 10th Ave

Fort Point

Cecil

MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00502

00499

1. PLACE OF DEATH a. COUNTY Cecil		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 16yrs7mos11days		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND		b. COUNTY Carroll		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		d. STREET ADDRESS 137 E. Green		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First MARIE		Middle A.		Last FRANKLIN		4. DATE OF DEATH Month January		Day 13		Year 1962													
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-21-1887		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 4		IF UNDER 24 HRS. Hours 13 Min. 0											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse				10b. KIND OF BUSINESS OR INDUSTRY Nursing				11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.				12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Benjamin G. Franklin						14. MOTHER'S MAIDEN NAME Agnes A. Shuey																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilat DUE TO 4-20-0 Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease DUE TO (c) Unknown												INTERVAL BETWEEN ONSET AND DEATH 3-5 days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema																							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that XXXXXX attended the deceased from June 2, 1945 to Jan. 13, 1962 and that death occurred at 8:45 from the causes and on the date stated above.																							
22a. SIGNATURE A. L. Mooney																ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED January 13, 1962			
22c. PHYSICIAN'S NAME (Type) A. T. MOONEY, M.D. Asst. Clinical Pathologist, VAH., Perry Point, Md.																22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				23b. DATE THEREOF 1/15/1962				23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) (State) Ft Myer, Virginia											
24. FUNERAL DIRECTOR'S SIGNATURE BENNINGTON								ADDRESS Havre DeGrace, Md.				25a. REC'D BY REGISTRAR JAN 17 '62				25b. REGISTRAR'S SIGNATURE Arthur S. Hines							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00503
00500
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY in 1b 65 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Warwick d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Joseph Last Glanding		4. DATE OF DEATH Month January Day 25 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1896
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) Delaware
13. FATHER'S NAME William Glanding		14. MOTHER'S MAIDEN NAME Elizabeth Golt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 1915-1918		17. INFORMANT Address Mrs. Eva M. Glanding, Warwick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-renal disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia (Death due to sudden onset of Fibrillation)			INTERVAL BETWEEN ONSET AND DEATH 20 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1961 to 25 Jan, 1962 that (I) (we) last saw the deceased alive on 25 Jan, 1962 , and that death occurred at 12:30 AM from the causes and on the date stated above.			
22a. SIGNATURE Wallace Openshain M.D. 22c. PHYSICIAN'S NAME (Type) Wallace Openshain, M.D.		22b. DATE SIGNED 26 Jan 62 22d. ADDRESS Cecil, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 27, 1962	23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery	23d. LOCATION (City, town or county) (State) Sudlersville, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Mellington, Md.		25a. REC'D BY REGISTRAR DATE JAN 29 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Evans

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TO HOSPITAL OR FUNERAL HOME: This law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 00504												00501	
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Penna. Phila. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md. Philadelphia c. LENGTH OF STAY IN 1b 16 days d. STREET ADDRESS 515 Wyndmoor Avenue						a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH A. GOLDEN						4. DATE OF DEATH January 13 19 62							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-21-1894		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Northumberland Co., Penna.			12. CITIZEN OF WHAT COUNTRY USA				
13. FATHER'S NAME JAMES GOLDEN						14. MOTHER'S MAIDEN NAME ROSE MONAHAN							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I				16. SOCIAL SECURITY NO. 209-14-6718		17. INFORMANT Hesp. Records, VA Hospital, Perry Point, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL, SEVERE DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DIABETES MELLITUS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH 7-10 Days Unk. Years	
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that XXXXXX attended the deceased from XXXXXX Dec. 28, 1961, to Jan. 13, 1962, and that death occurred at XXXXXX 8:15 P.M. from the causes and on the date stated above.													
22a. SIGNATURE A.L. Mooney M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 1-14-62			
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY, MD. Asst. Clinical Pathologist, VAH., Perry Point, Md.						22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL				23b. DATE THEREOF 1/15/1962		23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre				23d. LOCATION (City, town or county) (State) Phila., Penna.			
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS Havre DeGrace, Md.				25a. REC'D BY REGISTRAR DATE JAN 17 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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209-11-6718 West. Records, VA Hospital, Perry Point, Md.

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Dec. 28, 1917

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W. J. Bell, Jr., M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00505

00502

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perryville, Rural				c. LENGTH OF STAY IN 1b 50 Yrs			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Aikin				d. STREET ADDRESS Aikin			
3. NAME OF DECEASED (Type or print) First Alexander Middle Hasson Last Hasson				4. DATE OF DEATH Month Jan. Day 10 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5, 1875	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86		IF UNDER 24 HRS. Hours 86 Min. 86			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Train Dispatcher				10b. KIND OF BUSINESS OR INDUSTRY Penna. R. Road		11. BIRTHPLACE (County & State, or foreign country) Maryland. Cecil Co.	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME John A. Hasson				14. MOTHER'S MAIDEN NAME Martha E. Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) No				16. SOCIAL SECURITY NO. 716-01-7674			
17. INFORMANT Miss Gertrude Hasson, Perryville, Md.				Address			
18. CAUSE OF DEATH (Enter only one cause pertaining to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Paralysis right side Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Sclerosis DUE TO (c) Arterio Sclerosis				INTERVAL BETWEEN ONSET AND DEATH 4 days 4 yrs. 10 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Jan 6, 1962				20g. (County) Jan 9, 1962		20h. (State) Jan 9, 1962	
21. I certify that (I) (this hospital) attended the deceased from Jan 6, 1962 to Jan 9, 1962 , that (I) (we) last saw the deceased alive on Jan 9, 1962 , and that death occurred at Jan 10, 1962 , from the causes and on the date stated above.							
22a. SIGNATURE Clarence I. Benson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Jan 10 1962	
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson				22d. ADDRESS Port Deposit, Md.			
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE THEREOF Jan. 13, 1962		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION (City, town or county) (State) Port Deposit, Md. Rural.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson				ADDRESS Perryville, Md.		25a. REC'D BY REGISTRAR JAN 12 '62	
				25b. REGISTRAR'S SIGNATURE Clarence I. Benson			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00506 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00503

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Blkton		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Blkton (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Allen Last Jeffrey				4. DATE OF DEATH Month Jan. Day 29 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1906		9. AGE (in years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Assembly Mech.		10b. KIND OF BUSINESS OR INDUSTRY General Motors Plant		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Russell Jeffrey				14. MOTHER'S MAIDEN NAME Lulu Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 234-16-6340		17. INFORMANT Address Mrs. John A. Jeffrey, Blkton, Md. R.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage silicosis also cardia 523.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10m							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. DODSON				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-30-62	
EXAMINER'S NAME (Type) R.C. DODSON M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 1-30-62	22c. NAME OF CEMETERY OR CREMATORY Sanders Cemetery		22d. LOCATION (City, town, or county) (State) Clay, West Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Md.		24a. REC'D BY REGISTRAR DATE JAN 31 '62	24b. REGISTRAR'S SIGNATURE Charles E. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

00507

CERTIFICATE OF DEATH

Reg. Dist. No. 00504

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS Mill Lane	
3. NAME OF DECEASED (Type or print) First Stella Middle Rebecca Last Johnson		4. DATE OF DEATH Month 1 Day 21 Year 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1889
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Neal		14. MOTHER'S MAIDEN NAME Sarah Ann Dennison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Miss Patsy Johnson, Mill Lane, North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-4-62 Pulmonary Edema DUE TO (b) Hypertensive Cardiovascular Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis			INTERVAL BETWEEN ONSET AND DEATH 30 min. 5 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7 Jan, 1962, to 22 Jan, 1962, that I last saw the deceased alive on 22 Jan, 1962, and that death occurred at 12:05 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huebner M.D.		ADDRESS (Street, city or town, state) North East, Md. DATE SIGNED 1/22/62	
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-25-62	22c. NAME OF CEMETERY OR CREMATORY North East Methodist	22d. LOCATION (City, town, or county) (State) North East Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Md.	24a. REC'D BY REGISTRAR DATE JAN 30 '62
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10000

10000

Blank form with faint horizontal lines and vertical grid lines, typical of a medical certificate.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be completed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00508									
00505									
1. PLACE OF DEATH a. COUNTY Cecil					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point					c. LENGTH OF STAY IN 1b 13 Yrs, 5 Mths.				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D. C.				
3. NAME OF DECEASED (Type or print) BENJAMIN HARRISON JONES					f. STREET ADDRESS 132 Rhode Island Ave., N.W.				
5. SEX Male					6. COLOR OR RACE Negro				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH 3/9/95				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown					10b. KIND OF BUSINESS OR INDUSTRY Unknown				
11. BIRTHPLACE (County & State, or foreign country) North Carolina					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Milton Jones					14. MOTHER'S MAIDEN NAME Clara L. Harlee				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I					16. SOCIAL SECURITY NO. Unknown				
17. INFORMANT VA Records, VAH, Perry Point, Maryland					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial fibrosis DUE TO (c) Arteriosclerotic heart disease severe PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
INTERVAL BETWEEN ONSET AND DEATH 5-7 days									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that XX XXX XXXXX attended the deceased from August 2, 1948 to January 21, 1962 and that death occurred 8:10AM from the causes and on the date stated above.									
22a. SIGNATURE A. L. Mooney									
22b. DATE SIGNED 1-22-62									
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY Asst. Clin. Pathologist VAH, Perry Point, Maryland									
22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 1/23/1962									
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery									
23d. LOCATION (City, town or county) (State) Fort Myers, Virginia									
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Sons									
25a. REC'D BY REGISTRAR Havre de Grace, Md.									
25b. REGISTRAR'S SIGNATURE Arthur S. Kline									



Cell

Forty Point

13 Ave, 5 Bldg.

Washington, D. C.

Veterans Administration Hospital

132 Rhode Island Ave., N.W.

DEPARTMENT OF VETERANS AFFAIRS

January 21, 1962

Male Negro

2/10/62

SA

Unknown

Unknown

North Carolina

William Jones

Glenn J. Harlee

Yes

Unknown

VA Records, VA, Forty Point, Maryland

Washington, D. C.

Washington, D. C.

Washington, D. C.

Unknown

August 2, 1962

8:10AM

1-1-62

Washington, D. C.

Washington National Cemetery

Washington, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00509

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00506

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Deputy Medical Examiner should be notified by the Medical Examiner. The Deputy Medical Examiner should execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>					c. LENGTH OF STAY IN 1b <u>DOA</u>									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hacks Point</u>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					d. STREET ADDRESS <u>1</u>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARNE H. LIED</u>					4. DATE OF DEATH Month Day Year <u>January 17, 1962</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 26, 1896</u>		9. AGE (In years last birthday) <u>65</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Electric</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elec. Eng.</u>		11. BIRTHPLACE (State or foreign country) <u>Norway</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 1 YEAR Months Days Hours Min.						
13. FATHER'S NAME <u>Frederick C. Lied</u>					14. MOTHER'S MAIDEN NAME <u>Hilda Hjoeth</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>184-07-1793</u>					17. INFORMANT Address <u>Mrs. Mabel K. Lied Hacks Point, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Occlusion</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 Min</u>														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>														
ACTUAL SIGNATURE <u>R. C. DODSON</u> EXAMINER'S NAME (Type) <u>R. C. DODSON M.D.</u>					DATE SIGNED <u>Jan. 18, 1962</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 20, 1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fernwood Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Fernwood Penna.</u>								
23. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u> ADDRESS <u>Elkton, Md.</u>					24a. REC'D BY REGISTRAR <u>JAN 19 62</u> DATE									
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY in 1b 210 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) VA Hospital					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4300 Mansfield Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Norris			First J.		Middle Maher		Last		4. DATE OF DEATH Month January Day 9 Year 19 62		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 21 04		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheetmetal Worker				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William J. Maher					14. MOTHER'S MAIDEN NAME Hanna Norris						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) WW II				16. SOCIAL SECURITY NO. 705 12 2716		17. INFORMANT VA Hospital Records VAH Perry Point, Maryland				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (c) unknown (e), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 5-7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerosis generalized moderate										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that it (this hospital) attended the deceased from 6.13 to 1.9 , 19 62 , from 1.9 to 1.9 1962 , and that death occurred 4:15 a.m. from the causes and on the date stated above.											
22a. SIGNATURE A.L. Mooney M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 1-9-62			
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY						22d. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 1-12-62		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery			23d. LOCATION (City, town or county) Baltimore, Maryland			(State)	
24. FUNERAL DIRECTOR'S SIGNATURE L. J. RUCK & SONS FUNERAL HOME-Baltimore Md.					ADDRESS		25a. REC'D BY REGISTRAR JAN 11 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		



Conf

Perry Point

VA Hospital

210 days

Baltimore

1300 Harfield Ave.

Leher

1.

North

12 21 01

x

White

Postnatal Worker

William J. Hester

Hanna Morris

Baltimore, Maryland

U.S.A.

Yes

WW II

705 12 218

VA Hospital Records VAN Perry Point, Maryland

Stenochromism bilateral unresolved

2-7 days

Myocarditis heart disease

unknown

Myocarditis generalized nodules

x

x

6 13

6 19

60

1:12

1-9-62

x

Handwritten signature

... Medical Records, VAN Perry Point, Md.

Baltimore National Cemetery, Baltimore, Maryland

I. J. HUCK & SONS FUNERAL HOME-Baltimore Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00511
00509
00511

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN lb 1yr. 1mo. 7days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY New Jersey c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vineland d. STREET ADDRESS West Landis Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK M. MARINO 4. DATE OF DEATH January 25 19 62		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 5-16-91 9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber 10b. KIND OF BUSINESS OR INDUSTRY Barbering 11. BIRTHPLACE (County & State, or foreign country) Italy 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lorenzo Marino (deceased) 14. MOTHER'S MAIDEN NAME Marie Marabee (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-I 16. SOCIAL SECURITY NO. 137-22-7387 17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure (recurrent), hypertensive arteriosclerotic heart disease 606X DUE TO (b) Complicated by peritonitis due to perforated urinary bladder diverticulum Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus and ulceration of rectum 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in detail and date of occurrence) etiology unknown		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)			
22a. SIGNATURE A. L. Mooney 22c. PHYSICIAN'S NAME (Type) A. L. MOONEY 22b. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS 22e. DATE SIGNED 1-25-62	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 1-29-62 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART 23d. LOCATION (City, town or county) VINELAND, N.J. (State)		24. FUNERAL DIRECTOR'S SIGNATURE Wainwright Funeral Home, Vineland, N. J. ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE JAN 30 '62	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00512

00510

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calvert		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Graybeal Nursing Home		d. STREET ADDRESS 222 W. High St.	
3. NAME OF DECEASED (Type or print) Eugene P. May		4. DATE OF DEATH Jan. 7, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1889
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm & Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Labor	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph E. May	
14. MOTHER'S MAIDEN NAME Sarah Johnson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. 214-14-8605		17. INFORMANT Theodore May Chesapeake City Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Cardiac Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) arteriosclerotic heart disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 5 days 5 yrs.		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 215 61 115 62		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/6 1962 to 1/8 1962, saw the deceased alive on 1/6 1962 and that death occurred at 11 AM, from the causes and on the date stated above.		22a. SIGNATURE OF NEIL R. TAYLOR M.D.	
22b. DATE SIGNED 1/8/62		22c. PHYSICIAN'S NAME (Type) Neil R. Taylor Jr. M.D.	
22d. ADDRESS Rising Sun Maryland		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF Jan. 10, 1962		23c. NAME OF CEMETERY OR CREMATORY Johnstown Cemetery	
23d. LOCATION (City, town or county) Earleville		(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William Taylor Carlton M.D.		25. REC'D BY REGISTRAR DATE JAN 11 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
00513									
00511									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Morgan Nursing Home					d. STREET ADDRESS 1				
3. NAME OF DECEASED (Type or print) First Jefferson Middle Davis Last McCoy					4. DATE OF DEATH Month January Day 31 Year 1962				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 6, 1901		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (County & State, or foreign country) Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME Jefferson D. McCoy					14. MOTHER'S MAIDEN NAME Sadie Gross.				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.					17. INFORMANT Address Mrs. Sarah Ellen McCoy, Chesapeake City, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Ictus 581 DUE TO Chronic alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) INTERVAL BETWEEN ONSET AND DEATH 2 years 30 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from MAY 9, 1960 to JAN 30, 1962 , that (I) (we) last saw the deceased alive on JAN 30, 1962 , and that death occurred at 7 PM , from the causes and on the date stated above. 22a. SIGNATURE Henry U. Davis M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) HENRY U. DAVIS MD 22d. ADDRESS CHESAPEAKE CITY MD 22b. DATE SIGNED									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb, 3, 1962		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City, town or county) (State) Chesapeake City, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.						25a. REC'D BY REGISTRAR FEB 2 '62		25b. REGISTRAR'S SIGNATURE Arthur E. Harris	

00513



CHIEF OF POLICE

NEW YORK POLICE DEPARTMENT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be completed by the hospital or attending physician. Page 4 may be completed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00514

00512

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY -	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 36yrs.7mo.5days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 720 North Linwood Avenue	
3. NAME OF DECEASED (Type or print) BEN (NMI) MIDURA		4. DATE OF DEATH January 30 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (County & State, or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter Midura		14. MOTHER'S MAIDEN NAME Anna Lasek	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Peace time		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma right lung with metastasis DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (Name of person) attended the deceased from June 27 19 25 to January 30 19 62 and that death occurred at 2:50pm M, from the causes and on the date stated above.		22a. SIGNATURE S. Goldgraben M.D.	
22b. DATE 1-31-62		22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, Chief, Medical Service, V.A. Hospital, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/2/62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) Arlington, Alexandria, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE M.F.SADOWSKI & SONS, 1808 EASTERN AVENUE		25a. REC'D BY REGISTRAR DATE FEB 2 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

00113

TESTIMONY OF DEATH

00214



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120 North Lincoln Avenue

Testimony of Death

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Testimony of Death, V.A. North Point, N.C.

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Testimony of Death

VR A15 (4)
15M 7/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

INVESTIGATION



HEALTH DEPARTMENT

Investigation

Report of the

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN b 305 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 1151 New Jersey Ave., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE MITCHELL NICHOLSON		4. DATE OF DEATH Month Day Year January 19, 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/11/86
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Detective		10b. KIND OF BUSINESS OR INDUSTRY Store	11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Mitchell	
14. MOTHER'S MAIDEN NAME Mary Hardester		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. 577-18-2051		17. INFORMANT VA Records, VAH, Perry Point, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, RIGHT LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROSIS, GENERALIZED, SEVERE		INTERVAL BETWEEN ONSET AND DEATH 5-6 Days Unk. Unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from March 20, 19 61 to January 19, 19 62 and that death occurred at 9:AM , from the causes and on the date stated above.			
22a. SIGNATURE J. L. Garey M.D.		22b. DATE SIGNED 1/21/62	
22c. PHYSICIAN'S NAME (Type) J. L. Garey, M.D.		22d. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 1/22/62	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Arlington	23d. LOCATION (City, town or county) (State) Arlington, Va.
24. FUNERAL DIRECTOR'S SIGNATURE Bennington, Son, Havre de Grace, Md.		25a. REC'D BY REGISTRAR JAN 25 '62 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

M

POST

OFFICE OF THE

100

Perry Point

302 Days

Washington, D. C.

Veterans Administration Hospital

1121 New Perry Ave., N. C.

Female White

X

6/1/56

75

Core Detective

Store

Washington, D. C.

U.S.A.

John Mitchell

Perry Point

Yes

SV-1-2021

VA Records, VAM, Perry Point, Maryland

ROBERT P. LEMMON, RICHARD L. LEMMON

2-6 Days

ANTHROPOLOGICAL UNIT

Unit

ANTHROPOLOGICAL UNIT, GENERAL D. B. B. B.

Unit

100

March 30

61

January 19

100

J. I. Garvey, D. C.

VAM, Perry Point, Md.

Washington

Washington, D. C.

Washington, D. C.

TO HOSPITAL OR AFTER DEATH: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00518

00516

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE District Of Columbia COUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington		
c. LENGTH OF STAY IN 1b 45 Days			d. STREET ADDRESS 912-12th Street, S.E.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last FRANK ROBERT PEARSON			4. DATE OF DEATH Month Day Year 1 18 1962		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-14-95	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist			10b. KIND OF BUSINESS OR INDUSTRY Printing Industry		
11. BIRTHPLACE (County & State, or foreign country) Oxen Hill, Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN PEARSON			14. MOTHER'S MAIDEN NAME ETTA JOHNSON		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-1			16. SOCIAL SECURITY NO. 579-24-6840		
17. INFORMANT Hospital Records, VAH, Perry Point, Maryland			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema and congestion, bilateral severe DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Adenocarcinoma prostate gland with metastasis to periaortic lymph nodes					INTERVAL BETWEEN ONSET AND DEATH 1 hr. unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) lymph nodes		
20c. TIME OF INJURY Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (if (a) is (b)) attended the deceased from 12-4 to 1-18 and that death occurred 5:50pm from the causes and on the date stated above.					
22a. SIGNATURE J. L. Garey M.D.			22b. DATE 1-20-62		22c. ADDRESS Arlington National
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL			23b. DATE THEREOF 1/22/1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National
23d. LOCATION (City, town or county) Arlington, Va.			(State)		
24. FUNERAL DIRECTOR'S SIGNATURE Benjamin L. Son			25a. REC'D BY REGISTRAR JAN 25 '62		25b. REGISTRAR'S SIGNATURE C. L. L. Kline

M

Cecil

Port Point

As Dave

Washington

Veterans Administration Hospital

712-12th Street, S.W.

WANE

ROBERT

FRANK

18

AS

WHITE

5-11-92

66

Washington

Printing Industry (over Hill, Maryland)

JOHN FRANK

THE FRANK

W-1

579-21-2110 Hospital Records, VAN, Port Point, Maryland

Washington, D.C. and surrounding areas

Records

Administrative and General Records

Unknown

Administrative and General Records

Records

5:00 PM

5:00 PM

[Handwritten signature]

Administrative and General Records

Administrative and General Records

Administrative and General Records

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00519

00517

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton d. STREET ADDRESS Route 1, Box 71 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WEBSTER (NMI) First Middle Last		4. DATE OF DEATH Month Day Year January 26 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-03
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tom Phillips (deceased)		14. MOTHER'S MAIDEN NAME Mariah Gain (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Pyelonephritis, bilateral, acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Prostatic hypertrophy and urethral stricture obstruction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 7-10 days 10-12 days Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XXXXXX attended the deceased from January 20, 1962, to January 26, 1962, and that death occurred at 9:55am, from the causes and on the date stated above.			
22a. SIGNATURE A.L. Mooney		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 1-26-62
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY		22d. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/30/62	23c. NAME OF CEMETERY OR CREMATORY U. S. National Cem.	23d. LOCATION (City, town or county) (State) Beverly, New Jersey
24. FUNERAL DIRECTOR'S SIGNATURE WALLEY FUNERAL HOME - Chestertown, Md.		25a. REC'D BY REGISTRAR DATE JAN 31 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Kneass

2
Kenneth Walley

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DATE OF DEATH

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House 1, Box 1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician. Page may be signed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00520

00518

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland c. LENGTH OF STAY in b 4mos. 10 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 306 - 16th Street, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRED LINCOLN PRILLAMAN		4. DATE OF DEATH Month Day Year January 28th 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8, 1890
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY US Post Office	11. BIRTHPLACE (County & State, or foreign country) Greenhill, Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLIE PRILLAMAN	
14. MOTHER'S MAIDEN NAME ROSE BELL WOOD		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1	
16. SOCIAL SECURITY NO. 578 03 8597		17. INFORMANT Hospital Records, VAH., Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause pertaining to death) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia, bilateral, recurrent. 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Emphysema (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized.		INTERVAL BETWEEN ONSET AND DEATH 5 - 8 days Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 18th, 1961 to Jan. 28th, 1962 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on January 28, 1962 , and that death occurred at 5:10 AM from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney M.D.		22b. DATE SIGNED 1-28-62	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D., Asst. Clinical Pathologist, VAH., Perry Point, Md.		22d. ADDRESS Ft Myer, Virginia	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/29/1962	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Ft Myer, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON,		25a. REC'D BY REGISTRAR Havre DeGrace, Maryland 25b. REGISTRAR'S SIGNATURE Arthur S. ...	

M

Geoff

Director of Columbia

Perry Point, Maryland

Washington

Veterans Administration Hospital

306 - 10th Street, S.E.

WED

ILLINOIS

WILLIAM

January

28th

62

Male

Married

X

June 8, 1950

VI

Clark

US Post Office

Greenhill, Virginia

USA

WILLIAM WILLIAM

WOOD HILL WOOD

Yes

W-1

578 03 8597

Hospital Records, VAH, Perry Point, Md.

(BIOGRAPHICAL)

Pneumonia, bilateral, recurrent.

5 - 8 days

Empyema

Years

Arteriosclerosis, generalized.

X

January 28, 62

Sept. 10th 61

Jan. 28th 62

62

1-28-62

X

A. J. MOONEY, M.D., Asst. Clinical Pathologist, VAH, Perry Point, Md.

Virginia National

PT. York, Virginia

Have Police, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01779

00521

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 602 Woodsdale Road	
3. NAME OF DECEASED (Type or print) TONY (NMI) RASZIMAS		4. DATE OF DEATH January 31 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May ? 1891
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Tailoring & Designing	
11. BIRTHPLACE (County & State, or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Raszimas		14. MOTHER'S MAIDEN NAME Eva Maslen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus to right lung DUE TO (b) Thrombosis of iliac veins DUE TO (c) Complicated by bronchopneumonia (recurrent) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) & arteriosclerotic heart disease INTERVAL BETWEEN ONSET AND DEATH immediate			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that XXXXXX attended the deceased from <u>11/9/58</u> 19....., to <u>January 31 1962</u> xxxxxx <u>5:35am</u> , and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 1-31-62	22c. PHYSICIAN'S NAME (Type) A. L. MOONEY
22d. ADDRESS Asst. Clinical Pathologist, VAH, Perry Point, Md.		22e. REC'D BY REGISTRAR DATE FEB 7 '62	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 3/5/1962		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) Baltimore, Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE XXXXXXXXXX <u>XXXXXXXXXX</u>		25a. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

05500

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

00522
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
00519

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY in 1b 30 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. f. COUNTY Cecil g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Earlville h. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) CORA ANN REED		4. DATE OF DEATH Month 1 Day 28 Year 1962		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19-1946		9. AGE (In years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min. 15		11. IF UNDER 24 HRS. Hours 15 Min. 15							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT				10b. KIND OF BUSINESS OR INDUSTRY High School				11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Irby Irby G. Reed				14. MOTHER'S MAIDEN NAME Violet Newton				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no				16. SOCIAL SECURITY NO. Irby Trly Reed, Earlville, Md.				17. INFORMANT Trly Reed, Earlville, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured pelvis right leg arm and skull right side DUE TO (b) Internal injuries and abrasion left side of face DUE TO (c) and head and contusions of left leg. CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.																INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Stepped in front of a car.																			
20c. TIME OF INJURY Month, Day, Year 1 27 62 Hour 1:50 a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 282				20f. (City or town) Earlville (County) Cecil (State) Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 1-28-62							
EXAMINER'S NAME (Type) R.C. Dodson				Address Rising Sun, Md.				22a. NAME OF CEMETERY OR CREMATORY Johnstown Cem.				22b. LOCATION (City, town, or country) Earlville, Cecil Co., Md.				22c. REC'D BY REGISTRAR 1 '62				22d. REGISTRAR'S SIGNATURE Arthur L. Hume			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/31/62				23c. NAME OF CEMETERY OR CREMATORY Johnstown Cem.				23d. LOCATION (City, town, or country) Earlville, Cecil Co., Md.				23e. REGISTRAR'S SIGNATURE Edward Fellows				23f. ADDRESS Mellington, Md.			

MEDICAL CERTIFICATION



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STUDENT

Violent Newton

Tracy G. Reed

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Tracy Reed, Barville, Mo.

Fractured pelvis right leg and small right side

Internal injuries and abrasion left side of face

and head and contusions on left leg.

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Stopped in front of a car.

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Rising Sun, Mo.

E.O. Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00523

00520

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Elkton		d. STREET ADDRESS Nottingham Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Clarence A. Rothwell				4. DATE OF DEATH Month Day Year Jan 4 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 31, 1896	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		10b. KIND OF BUSINESS OR INDUSTRY Chemical		11. BIRTHPLACE (County & State, or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Levi Hutchison Rothwell				14. MOTHER'S MAIDEN NAME Clarissa Dickerson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW #1				16. SOCIAL SECURITY NO. 220-01-5344			
17. INFORMANT Mrs. Clarissa Dennis, Elkton, Md.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 4200 } DUE TO Conditions, if any, which gave rise to immediate cause (b) Congestive Heart Failure (c) Arteriosclerotic Heart Disease cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 3 days 3 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 4 1962 to Jan 7 1962, that (I) (we) last saw the deceased alive on Jan 4 1962, and that death occurred at 7:35 M, from the causes and on the date stated above.							
22a. SIGNATURE Joseph G. Lanzi, M.D.				22b. DATE SIGNED 1/4/62			
22c. PHYSICIAN'S NAME (Type) JOSEPH G. LANZI, M.D.				22d. ADDRESS 205 W. Main St., Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-8-62		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION (City, town or county) (State) Elkton, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				25a. REC'D BY REGISTRAR JAN 9 '62			
ADDRESS Elkton, Md.				25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "CERTIFICATE OF DEATH" and "MAY 1961" are faintly visible.]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 00521

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nurseing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle P. Last Rutter		4. DATE OF DEATH Month Jan. Day 19 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1879
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Conductor		10b. KIND OF BUSINESS OR INDUSTRY Rail Road	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME William Rutter	
14. MOTHER'S MAIDEN NAME Caroline Kennedy		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. INFORMANT		Address Charles H. Green, Rising Sun, Md. Rural	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) unknown			INTERVAL BETWEEN ONSET AND DEATH 2 hours.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 11 , 19 62 , to Jan. 19 , 19 62 that I last saw the deceased alive on Jan. 19 , 19 62 , and that death occurred at 7:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 1/20/62			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton, Maryland	
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 1-22-1962	
22c. NAME OF CEMETERY OR CREMATORY Hopewell cemetery		22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson's Son		ADDRESS Perryville, Md.	
24a. REC'D BY REGISTRAR JAN 22 '62		24b. REGISTRAR'S SIGNATURE Charles H. Green	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. It is to be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

00525

00522

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson	
c. LENGTH OF STAY IN 1b 87 Days		d. STREET ADDRESS 501 Charles Street	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veteran Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARIE JOANNA SEDLACK		4. DATE OF DEATH Month Day Year January 7, 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-05
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY - - - -	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph L. Sedlack (Living)	
14. MOTHER'S MAIDEN NAME Marie Stipsich (Deceased)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 217-20-2196		17. INFORMANT VA Records, VAH, Perry Point, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATELECTASIS RIGHT LUNG AND PLEURAL EFFUSION 170X DUE TO BILAT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA OF RIGHT BREAST, WITH METASTASIS TO LUNGS, RIBS, AND OTHER ORGANS DUE TO LUNGS, RIBS, AND OTHER ORGANS (c) LUNGS, RIBS, AND OTHER ORGANS		INTERVAL BETWEEN ONSET AND DEATH 7-10 Days 2 1/2 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/12/1961 , to 1/7/1962 , and that death occurred at 3:35 PM from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney M.D.		22b. DATE SIGNED 1/7/62	
22c. PHYSICIAN'S NAME (Type) A. L. Mooney, M.D.		22d. ADDRESS VAH, Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 10, 1962	23c. NAME OF CEMETERY OR CREMATORY Prospect Hill Cemetery
23d. LOCATION (City, town or county) Towson, Md.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns Son's		25a. REC'D BY REGISTRAR DATE JAN 11 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00523

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton 21	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 211 E.High Street		d. STREET ADDRESS 211 East High, Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lucinda Starling		4. DATE OF DEATH Month Day Year January 22 1962	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/6/1877
9. AGE (In years last birthday) 84		IF UNDER 1 YEAR Months Days 3 16	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Davis		14. MOTHER'S MAIDEN NAME Ella Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
INFORMANT		Address Elsie Badson-89 New London Ave. Nwk, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum with Metastasis 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Secondary Anemia DUE TO (c) Cardiac		INTERVAL BETWEEN ONSET AND DEATH 6-Mos. 4-Mos. 10-Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/18/ 1961, to 1/22/ 1962, that I last saw the deceased alive on 1/21/ 1962, and that death occurred at 6:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE James L. Johnson M.D. 245 East High Street 1/23/62 PHYSICIAN'S NAME (Type) James L. Johnson M.D. Elkton, Cecil Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/62	
22c. NAME OF CEMETERY OR CREMATORY Rolling Green Cem.		22d. LOCATION (City, town, or county) (State) West Chester, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Coker R. Bell - 909 Poplar St.		24a. REC'D BY REGISTRAR DATE JAN 26 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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CERTIFICATE OF DEATH

Reg. Dist. No. 00527 00524

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RISING SUN - R2		c. LENGTH OF STAY IN 1b 14 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First POSEY Middle G. Last TAYLOR		4. DATE OF DEATH Month JANUARY Day 15 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 30, 1892
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME STEPHEN TAYLOR		14. MOTHER'S MAIDEN NAME JANE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Muriel Taylor, Rising Sun Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/15, 1962 to 11/15, 1962 , that I last saw the deceased alive on 11/15, 1962 , and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md DATE SIGNED 1/15/62 ACTUAL SIGNATURE Neil Taylor M.D. PHYSICIAN'S NAME (Type) Neil Taylor Jr. Rising Sun, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/18/62	22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	22d. LOCATION (City, town, or county) (State) Forest Green Park Co. Md
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M. Reed, Rising Sun, Md		ADDRESS Rising Sun, Md	
24a. REC'D BY REGISTRAR DATE JAN 17 1962		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED Cecilia		2. SEX F		3. AGE 65		4. DATE OF BIRTH 1912	
5. PLACE OF BIRTH Maryland		6. OCCUPATION Housewife		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1935	
9. PLACE OF DEATH Home		10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. DATE OF DEATH 1978	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESS		15. SIGNATURE OF PHYSICIAN		16. SIGNATURE OF REGISTRAR	
17. SIGNATURE OF CLERK		18. SIGNATURE OF JUDGE		19. SIGNATURE OF SHERIFF		20. SIGNATURE OF CORONER	
21. SIGNATURE OF DISTRICT ATTORNEY		22. SIGNATURE OF COUNTY CLERK		23. SIGNATURE OF TOWNSHIP CLERK		24. SIGNATURE OF VILLAGE CLERK	
25. SIGNATURE OF CITY CLERK		26. SIGNATURE OF TOWNSHIP CLERK		27. SIGNATURE OF VILLAGE CLERK		28. SIGNATURE OF CITY CLERK	
29. SIGNATURE OF TOWNSHIP CLERK		30. SIGNATURE OF VILLAGE CLERK		31. SIGNATURE OF CITY CLERK		32. SIGNATURE OF TOWNSHIP CLERK	
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97. SIGNATURE OF CITY CLERK		98. SIGNATURE OF TOWNSHIP CLERK		99. SIGNATURE OF VILLAGE CLERK		100. SIGNATURE OF CITY CLERK	

1. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, Baltimore, Maryland.

2. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, Baltimore, Maryland.

3. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, Baltimore, Maryland.

4. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, Baltimore, Maryland.

5. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, Baltimore, Maryland.

6. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, Baltimore, Maryland.

7. I hereby certify that the above is a true and correct copy of the original record as it appears in the files of the Department of Health, Baltimore, Maryland.

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If the deceased was 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00528											
1. PLACE OF DEATH e. COUNTY Cecil MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Delaware					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Perry Point						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Broomall					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						d. STREET ADDRESS 332 Hastings Blvd.					
3. NAME OF DECEASED (Type or print) First PAUL Middle (NMI) Last THOMPSON SR.						4. DATE OF DEATH Month January Day 20 Year 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/21/93		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Postal Clerk				10b. KIND OF BUSINESS OR INDUSTRY US POSTAL SERVICE				11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Thompson						14. MOTHER'S MAIDEN NAME Annie Hartman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WM I 205-28-8671		17. INFORMANT VA Records, VAH, Perry Point, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL, UNRESOLVED DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CARCINOMA, BRONCHOGENIC, RIGHT LOWER BRONCHUS WITH (c) METASTASIS TO HILOR NODES ARTERIOSCLEROSIS, GENERALIZED, SEVERE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that XX (this hospital) attended the deceased from 6/24/57 to 1/20/62 , and that death occurred 8:15AM from the causes and on the date stated above. 22a. SIGNATURE J. L. Garey M.D. 22b. DATE SIGNED 1/20/62 22c. PHYSICIAN'S NAME (Type) J. L. Garey, M. D. 22d. ADDRESS VAH, Perry Point, Md. 22e. REC'D BY REGISTRAR Arthur S. Kraus 22f. REGISTRAR'S SIGNATURE Arthur S. Kraus											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1-23-1962		23c. NAME OF CEMETERY OR CREMATORY Glenwood Memorial Gardens				23d. LOCATION (City, town or county) (State) Broomall, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson + Son Perryville, Md.											

List

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[Figure 1]

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00529

00526

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 7 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 401 Maryland Ave.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS 401 Maryland Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Caroline Morgan Tretheway				4. DATE OF DEATH Month Day Year January 14, 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 8, 1891	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (County & State, or foreign country) Cardiff, Wales	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edward Morgan				14. MOTHER'S MAIDEN NAME Sarah Haddock			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. Mrs. Elmer Frey, Jr., Elkton, Md.			
17. INFORMANT Mrs. Elmer Frey, Jr., Elkton, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) Arteriosclerotic heart disease, decompensated 3mo. DUE TO (c) Carcinoma, breast, with metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Carcinoma, breast, with metastases						INTERVAL BETWEEN ONSET AND DEATH 1 hr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 9, 1960 to 1-14-62 , 19 62 that (I) (we) last saw the deceased alive on 1-14-62 , and that death occurred at 9:24 AM , from the causes and on the date stated above.							
22a. SIGNATURE William D. Johnson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-14-62	
22c. PHYSICIAN'S NAME (Type) William D. Johnson M.D.				22d. ADDRESS 123 Sinslerly Ave, Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/17/62		23c. NAME OF CEMETERY OR CREMATORY Memorial Shrine Cemetery, Dallas, Pa.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				25a. REC'D BY REGISTRAR DATE JAN 31 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Harris	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Cecil

Erikson

601 Maryland Ave.

Maryland

Erikson

401 Maryland Ave.

Caroline

Morgan

Trevelyan

January 14, 1902

Female White

Feb. 8, 1891

70

Houswife

Garrett, Wales

U.S.A.

Edward Morgan

Samuel Haddock

No

Mrs. Rimer Trev. Jr., Erikson, Md.

Serial

2/12/02

National Spring Cemetery, Dallas, Tex.

Erikson, Md.

TO HOSPITAL OR A HOSPITAL. The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00530

CERTIFICATE OF DEATH

00527

Item 2 Film G305 1/15/62 iwk

1. PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHESAPEAKE CITY c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MORGAN NURSING HOME		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md b. COUNTY CECIL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE CITY d. STREET ADDRESS 1107 Lincoln Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JENNIE Middle B. Last WALTERS		4. DATE OF DEATH Month JANUARY Day 4 Year 1962	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 6, 1879 82 yrs.
9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES WALTERS	
14. MOTHER'S MAIDEN NAME HANNAH BOULDEN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT THOMAS CORNBROOKS COLLINGSWOOD, N. J.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL DISEASE DUE TO 4222 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) LOBAR PNEUMONIA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH TWO WEEKS 30 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL MEDICAL CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from APRIL 1936 to JAN 4, 1962 ; that (I) (we) last saw the deceased alive on JAN 4, 1962 , and that death occurred at 11:00 from the causes and on the date stated above.			
22a. SIGNATURE Henry U. Davis		22b. DATE SIGNED 1/5/62	
22c. PHYSICIAN'S NAME (Type) HENRY U. DAVIS MD		22d. ADDRESS CHESAPEAKE CITY MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1/6/62	
23c. NAME OF CEMETERY OR CREMATORY BETHEL CEMETERY		23d. LOCATION (City, town or county) (State) NR. CHESAPEAKE CITY, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		25a. REC'D BY REGISTRAR JAN 9 '62	
ADDRESS ELLEN, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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00230

REVENUE - DE GRANT

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1950

CHARTERED BY THE BOARD OF DIRECTORS

FOR THE YEAR 1950

IN THE AMOUNT OF

\$100,000.00

FOR THE PURPOSE OF

CONSTRUCTION OF

A NEW BRIDGE

OVER THE RIVER

AT THE

LOCATION OF

THE OLD BRIDGE

AND THE

NEW BRIDGE

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